The Notice of Authorization (NOA)

The Notice of Authorization (NOA) (Figures 3-3a and 3-3b), a computer-generated form sent to the provider following final adjudication of a Treatment Authorization Request (TAR), is printed with the same information as originally submitted. Presently the NOA is used either to request payment of allowed services or to request a re-evaluation of modified or denied services on a TAR.

NOAs issued for beneficiaries with Aid Code 50, 8F, 84, 85, 88, and 89, will list the following informational message:

> Please note: This beneficiary may only be eligible for reduced CMSP benefits. Please verify eligibility and allowable procedures prior to rendering services.

Providers may request a re-evaluation period of 180 days for denied and/or additional procedures requested in certain instances. Changes to the billed amount or procedures not requiring prior authorization will *not* be considered. Orthodontic treatments continue to be excluded from this change.

Re-evaluations may be allowed when

- another procedure requiring prior authorization has been requested
- there is a reversal of denied procedures, e.g., missing x-rays have been submitted.
- there is a complex treatment plan

Denti-Cal has created the following NOA message when a re-evaluation has been requested:

> The submitted changes have been reviewed. Original authorization period still valid.

Denti-Cal has revised the following NOA message when a re-evaluation has been requested:

> Resubmission not processed. No additional information received. Original authorization period still valid.

To expedite processing and prevent delays or possible denial, please remember to check the box found in the upper right corner of the NOA. ***Only one re-evaluation may be requested per NOA and it must be received prior to the expiration date.***

Prior to completing the form, verify that the information printed on the form is correct.

The NOA is printed by Denti-Cal with the following information:

1. Authorized period of time (180 days)
2. Patient information (except Medi-Cal ID Number)
3. Provider information
4. Procedures allowed, modified, disallowed
5. Allowances
6. Adjustment codes

Denti-Cal will indicate on the NOA if the services requested are allowed, modified or disallowed. For those allowed services, fill in the appropriate shaded areas on the top portion of the NOA form. Submit the completed and signed form, marked "DENTI-CAL COPY," as a claim for payment for the services performed. Also, fill in the appropriate shaded areas on the "DENTIST COPY" and retain this copy for your records.

The NOA has a statement printed on the bottom of the form that reads: "NOTE: Authorization does not guarantee payment. Payment subject to patient's eligibility." This statement has been added to remind the dentist to verify the patient's eligibility prior to providing services.

If the allowed period of time on your NOA has expired and none of the authorized services have been completed, please send the expired NOA back to Denti-Cal so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

How to Complete the NOA

The following fields on the NOA require completion by the dental office. The required fields are listed in the order that they appear on the NOA.

5. **PATIENT MEDI-CAL IDENTIFICATION NUMBER:** Enter the patient's 10-digit State Recipient Identifier as it appears on the Medi-Cal identification card (Benefits Identification Card). Completion of this field is required.

9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the

number of films enclosed. All radiographs and any attachments should be clearly identified with the patient's name and social security number, the date the x-ray was taken, and the provider's name and provider number.

Four or more multiple x-rays must be mounted. If the x-rays are unmounted or undated, the request for authorization or payment will be denied. It is acceptable to submit three or less radiographs unmounted, but the envelopes in which these x-rays are submitted must be dated. X-rays taken on different days must be submitted in different dated envelopes. Be sure to document in the Comments area of the claim (box 34) any condition that cannot be viewed on the x-ray.

Final treatment x-rays of endodontic treatment are necessary when submitting for payment of Procedure 511 (Anterior Root Canal Therapy), Procedure 512 (Bicuspid Root Canal Therapy), Procedure 513 (Molar Root Canal Therapy), Procedure 530 (Apicoectomy-Surgical procedure in conjunction with root canal filling), and Procedure 531 (Apicoectomy-Separate surgical procedure).

If additional treatment not requiring prior authorization is added to the NOA, x-rays or narrative documentation must be submitted, as appropriate, to justify the additional service.

Denti-Cal recycles *all* radiographs and photographs *unless their return is specifically requested*. This change in procedure, suggested by a number of providers, is expected to help contain unnecessary program costs.

Providers are instructed to clearly write “Do Not Recycle” on x-ray mailing envelopes when radiographs and photographs are to be returned. Use no other words or phrases, especially the word “Return” as the United States Postal Service interprets this to mean “Return to Sender” and sends the envelopes back to Denti-Cal.

Stickers are available for affixing to x-ray mailing envelopes. It is imperative that preimprinted or typed return address x-ray mailing envelopes be used. To request a supply of these stickers, please mark the box indicated on the Forms Reorder Request Form and mail or fax order to:

Shamrock Companies, Inc.
410 E. Grantline Rd.
Tracy, CA 95376
fax: 209/832/2105

If your office has a device such as a scanner that can transfer radiographs onto paper, Denti-Cal will accept the paper copy instead of the regular film. Paper copies of x-rays must be of good quality to be accepted. If the resolution of the paper image is inadequate, Denti-Cal will request the original film, which can delay processing. Be sure to indicate on the paper copy the date the x-ray was taken and which side of the mouth. Paper copies of x-rays will not be returned.

10. **OTHER ATTACHMENTS?** Check "yes" if additional documents are attached to the claim or TAR form. Other attachments include related correspondence, periodontal charts, operating room reports, or physician’s report describing the patient’s specific medical condition. If the physician’s report is concerning a homebound patient, be sure to document the reason the patient cannot leave the private residence and the length of time the patient will be homebound. Do not place attachments inside the x-ray envelope.

11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the patient was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the patient's accident or injury was "Employment Related" check "yes."

13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private or employer paid dental insurance carrier. You must bill the other insurance carrier prior to submitting the claim to Denti-Cal. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, Social Security number and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits or denial letter. See Section 2 of this man-

ual for additional information on other coverage.

16. **CHDP - CHILD HEALTH AND DISABILITY PREVENTION?** Check "yes" if the treatment is related to a previous CHDP screening.

23. **POE (PROOF OF ELIGIBILITY) AREA:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).

41. **DELETE:** If treatment was not performed, place an "X" in the column corresponding to the treatment not performed. Do NOT strike out the entire line.

29. **DATE SERVICE PERFORMED:** Indicate the date the service was performed. Use six (6) numerical digits, e.g., mm/dd/yy.

33. **TREATING MEDI-CAL PROVIDER NUMBER:** If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the treating provider number of the dentist or dental hygienist who performed the service. The treating provider number should be entered on the claim line for each service performed. The alpha character "D" should precede the number, e.g., D-2-3-4-5-6.

    A treating provider number is not needed for the following procedures: 045, 046, 047, 049, 050, 061, 062, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 125, 160, 955, 956 and 957.

    If there is only one dentist or dental hygienist treating patients at a service office, the field “Treating Medi-Cal Provider Number” does not need to be completed for any claim line.

44. **DATE PROSTHESIS ORDERED:** If an approved prosthesis cannot be placed, indicate the date the prosthesis was ordered from the dental laboratory.

45. **PROSTHESIS LINE FIELD:** Indicate the number of the line corresponding to procedure billed for the undelivered prosthesis.

34. **COMMENTS:** Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. It is helpful to note in this area if additional documentation is attached.

36. **PATIENT SHARE-OF-COST AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of the patient's share of cost collected by or due to your office from a recipient who has a share-of-cost obligation.

37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedure. If either field 13 (OTHER DENTAL COVERAGE) or field 14 (MEDI-CARE DENTAL COVERAGE) is checked "yes," the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial letter from the private dental insurance carrier or Medicare must be attached to the claim for payment.

38. **DATE BILLED:** Enter the date the form is mailed using the six (6) numeric digit format, e.g., mm/dd/yy.

39. **SIGNATURE BLOCK:** The provider, or person authorized by the provider, must sign their own name in this signature box and date the form when requesting payment. Rubber stamp signatures are not acceptable.

    Additional services not requiring prior authorization may be added to the NOA. However, x-rays or documentation must be sent with the NOA to justify the additional services. After providing all necessary information on the form, please follow these steps:

    - Send the NOA marked "DENTI-CAL COPY" to Denti-Cal. Multi-page NOAs should be returned together.
    - Retain the form marked "DENTIST COPY" for your office records.
    - Sign and date the form marked “DENTI-CAL COPY.”
    - If x-rays are being submitted, enclose them in the green-bordered x-ray envelope and attach it to the NOA.
    - Mail completed forms in the large green-bordered envelopes that have been provided. Up to 10 forms can be mailed in a single envelope.

- Mail NOAs to the post office box listed below:

  Denti-Cal
  California Medi-Cal Dental Program
  P.O. Box 15610
  Sacramento, CA 95852-0610

To be considered for full payment (100 percent of the SMA amount), NOAs must be received by Denti-Cal not more than six months after the end of the month in which the final service is performed. NOAs that are received within nine months after the end of the month in which the final service was performed will be considered for payment at 75 percent of the SMA amount. NOAs that are received within one year after the end of the month in which the final service was performed will be considered for payment at 50 percent of the SMA amount. This billing limitation policy applies to each completed date of service.

Extensions of Time

Extensions of time are no longer granted. Instead the time frame for approving Treatment Authorization Requests has changed from 120 to 180 days.

Re-Evaluations

Only one request for re-evaluation per NOA is allowed and it must be received prior to the expiration date.

To request re-evaluation of a TAR, follow these steps:

1. Check the box marked "RE-EVALUATION IS REQUESTED" at the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include documentation and enclose x-rays as necessary.
4. Return to:

   Denti-Cal
   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609

After the re-evaluation is made, a new NOA will be generated and sent to your office.

Outstanding Treatment Authorization Requests (TARs)

Since TARs can remain outstanding in the automated system for an extended length of time, Denti-Cal may deny authorization or payment of services based on Adjudication Reason Code 300A ("Procedure recently authorized to a different provider"). Denti-Cal may reconsider denial of authorization or payment of services that are duplicated on an outstanding TAR under the following circumstances:

- written notification from the patient stating that he or she will not be returning to the original provider's office;
- closure of the original provider's office;
- sale of the original provider's practice;
- death of the original provider;
- refusal of the original provider to return the Notice of Authorization;
- treatment (such as extraction) was provided on an emergency basis by one dentist when authorization for the same treatment was granted previously to a different dentist.

For reconsideration of denial of authorization or payment under these circumstances, please follow these guidelines:

1. Obtain a written statement from your patient that treatment will not be provided by the original dentist.
2. For an Explanation of Benefits (EOB) showing denial of payment: Attach your patient's statement to the EOB and follow the normal procedures for the Claim Inquiry Form.
3. For a Notice of Authorization (NOA) showing denial of treatment authorization: Attach your patient's statement and any other supporting documentation to the NOA, and submit the NOA with necessary x-rays to obtain reauthorization of the services. Denti-Cal will send to your office a new NOA showing the approved and allowed services and will void the original TAR. A new NOA will be sent to the original provider with the previously authorized procedures disallowed. Disallowed services will be indicated with Adjudication Reason Code 555 ("Authorization of this

line is no longer valid") due to one of the following reasons:

a. Patient is/was being treated elsewhere;

b. Treatment was performed as an emergency;

c. A new claim/TAR is being processed.

Beneficiary Notification of TAR Status

Denti-Cal sends all Medi-Cal dental beneficiaries and/or their authorized representatives written notification when services on their treatment authorization requests (TARs) have been denied, modified or deferred. The notification indicates the status of the TAR and explains why the requested service was denied, modified or deferred. Beneficiaries do not receive written notification of approved TARs or services that have been performed.

When the dental office prepares a TAR for a beneficiary with an authorized representative who is not identified on the Medi-Cal card, the representative's name and address should be included in the "Comments" box (field 34) on page 2 of the Denti-Cal TAR form. This will assist Denti-Cal in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information.

Your patients may contact you for assistance with inquiries concerning their TARS. If you are unable to answer their questions, please refer your patients directly to Denti-Cal. A Denti-Cal patient or authorized representative may call the Beneficiary Services toll-free telephone number at (800) 322-6384 for assistance with inquiries about denied, modified or deferred TARs.

Figure 3-3a
NOTICE OF AUTHORIZATION: DENTI-CAL COPY

STAPLE HERE

DO NOT WRITE IN THIS AREA

STAPLE HERE

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

03318100124

NOTICE OF AUTHORIZATION

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/03
TO: 05/13/04

RE-EVALUATION IS REQUESTED ☐ YES

PAGE 1 OF 1

1. BENEFICIARY NAME (LAST, FIRST, M.I.)	2. BENEFICIARY SOC. SEC. NO.	3. SEX	4. BENEFICIARY BIRTHDATE	5. BENEFICIARY MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	M x F	MO. mm DAY dd YR yyyy	

9. RADIOGRAPHS ATTACHED? CHECK IF YES / HOW MANY?	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED? YES	13. OTHER DENTAL COVERAGE? CHECK IF YES / 16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James DDS Gxxxxx-01
30 Main Street xxx-xxx-xxxx
Anytown, CA xxxxx-xxxx

23. BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER ARCH	27. SURFACES		28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. CODE	33. TREATING MEDI-CAL PROVIDER NO.
	19		1	Full Cast Crown		01	660	410.00	340.00		
	20		2	Full Cast Crown		01	660	410.00	340.00		
			3								
			4								
			5								
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			21								
			22								

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

- ADJUSTMENT CODES - SEE PROVIDER MANUAL
- AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO BENEFICIARY ELIGIBILITY.
- AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
- USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	820.00
46. TOTAL ALLOWANCE	680.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION
- FILL IN SHADED AREAS IF APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. **TREATMENT COMPLETED - PAYMENT REQUESTED**
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ SIGNATURE _____ DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SEND THIS PORTION TO DENTI-CAL • RETAIN "DENTIST COPY" FOR YOUR RECORDS

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

Figure 3-3b

NOTICE OF AUTHORIZATION: DENTIST COPY

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

NOTICE OF AUTHORIZATION

03318100124

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/03
TO: 05/13/04

RE-EVALUATION IS REQUESTED ☐ YES

PAGE 1 OF 1

1. BENEFICIARY NAME (LAST, FIRST, M.I.)	2. BENEFICIARY SOC. SEC. NO.	3. SEX (M / F)	4. BENEFICIARY BIRTHDATE (MO. DAY YR)	5. BENEFICIARY MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	X	mm dd yyyy	

9. RADIOGRAPHS ATTACHED? CHECK IF YES / HOW MANY?	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED?	13. OTHER DENTAL COVERAGE? CHECK IF YES	16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James DDS Gxxxxx-01
30 Main Street xxx-xxx-xxxx
Anytown, CA xxxxx-xxxx

23. BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER A-T	27. SUR-FACES		28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. CODE	33. TREATING MEDI-CAL PROVIDER NO.
	19		1	Full Cast Crown		01	660	410.00	340.00		
	20		2	Full Cast Crown		01	660	410.00	340.00		
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44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

* ADJUSTMENT CODES - SEE PROVIDER MANUAL
* AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO BENEFICIARY ELIGIBILITY.
* AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
* USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	820.00
46. TOTAL ALLOWANCE	680.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION

- FILL IN SHADED AREAS IF APPLICABLE
- SIGN AND RETURN "DENTI-CAL COPY" FOR PAYMENT
- RETAIN "DENTIST COPY" FOR YOUR RECORDS

DENTIST MUST SIGN "DENTI-CAL COPY"

SEND "DENTI-CAL COPY" TO DENTI-CAL • RETAIN THIS PORTION FOR YOUR RECORDS

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.